



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Sentrix Pharmacy and Discount, L.L.C.

Respondent Name

Sunz Insurance Company

MFDR Tracking Number

M4-17-3433-01

Carrier's Austin Representative

Box Number 20

MFDR Date Received

July 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the attending physician prescribed medication to the injured employee; the pharmacy dispensed medication pursuant to the authorized physician's orders ... The Provider reasonably relied upon a validly executed prescription for medically necessary medication and dispense same therefrom."

Amount in Dispute: \$2,078.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medications in question were never prescribed by the treating doctor..."

Response Submitted by: Lewis & Backhaus, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2017	Pharmacy Services - Compound	\$2,078.06	\$1,718.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.500 provides definitions related to pharmaceutical services.
3. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 010 – Services not authorized or prescribed by the treating physician.

Issues

1. Did Sunz Insurance Company (Sunz) raise a new defense pursuant to 28 Texas Administrative Code §133.307?
2. Is Sunz' denial of payment for the disputed compound supported?
3. Is Sentrix Pharmacy and Discount, L.L.C. (Sentrix) entitled to reimbursement for the disputed compound?

Findings

1. In its position statement, Lewis & Backhaus, P.C. argued on behalf of Sunz, "... the Respondent had a physician review the medications for necessity. Dr. Donald Mauldin, MD, ... reviewed the claimants history, treatment, including Dr. DePrang's records and found that these medications are, and were unnecessary."

28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

Review of the submitted documentation finds that Sunz failed to present a medical necessity denial to Sentrix in accordance with 28 Texas Administrative Code §133.240 prior to the date the request for medical fee dispute resolution (MFDR) was filed. The division concludes that this defense presented in Lewis & Backhaus, P.C.'s position statement shall not be considered for review because this assertion constitutes a new defense pursuant to 28 Texas Administrative Code §133.307(d)(2)(F).

2. Sentrix is seeking reimbursement of 2,078.06 for a compound dispensed on May 19, 2017. Sunz denied disputed compound with claim adjustment reason code 010 – "SERVICES NOT AUTHORIZED OR PRESCRIBED BY THE TREATING PHYSICIAN."

Review of the submitted documentation finds a prescription from Dr. Clifford DePrang for the compound in question.

Lewis & Backhaus, P.C. argued that Dr. DePrang agreed with Dr. Mauldin's assessment regarding medical necessity "and evidenced by the fact that they were not prescribed." The documentation presented by Lewis & Backhaus, P.C. did not support that a request for a statement of medical necessity as defined by 28 Texas Administrative Code §134.500(13) was presented to the prescribing doctor in accordance 28 Texas Administrative Code §134.502(e). Therefore, Sunz' denial of payment for this reason is not supported.

3. 28 Texas Administrative Code §134.503 applies to the compounds in dispute and states, in pertinent part:
 - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
 - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
 - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Compound Fee	NA	\$15.00	NA	\$15.00	\$0.00	\$0.00
Salt Stable LS Base	00395602157 Brand Name	\$3.36	170.4 gm	\$624.07	\$572.54	\$572.54
Baclofen 4%	00395803243 Generic	\$35.63	9.6 gm	\$427.56	\$342.05	\$342.05
Amitriptyline 2%	00395804843 Generic	\$18.24	4.8 gm	\$109.44	\$87.55	\$87.55
Ketoprofen 10 %	00395805643 Generic	\$10.45	24.0 gm	\$313.50	\$250.80	\$250.80
Amantadine 8%	00395805843 Generic	\$24.225	19.2 gm	\$581.40	\$465.12	\$465.12
Gabapentin 5%	10695003507 Invalid NDC	\$0.00	12.0 gm	\$0.00	\$360.00	\$0.00
					Total	\$1,718.06

The total reimbursement is therefore \$1,718.06. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,718.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$1,718.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 29, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, 37 Texas Register 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.